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**FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY**

**FACTORS THAT INFLUENCE HIV STATUS DISCLOSURE AMONG THE ELDERLY
IN SHURUGWI**

**BY
SHELTER VANDIRAYI
R144306P**

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SUPERVISOR: DR MUTAMBARA

APPROVAL FORM



Faculty of Social Sciences

Department of Psychology

The undersigned certify that they have read and recommended to the Midlands State University for the acceptance of a dissertation titled:

Research topic: FACTORS THAT INFLUENCE HIV STATUS DISCLOSURE AMONG THE ELDERLY IN SHURUGWI.

Submitted by Vandirayi Shelter, **Registration Number** R144306P in partial fulfillment of the requirements for a Bachelor of Science Honours Degree in Psychology

SUPERVISOR

DR J Mutambara

.....

CHAIRPERSON

Mrs Ncube

.....

EXTERNAL EXAMINER

.....

DATE

JUNE 2018

RELEASE FORM



NAME OF AUTHOR: SHELTER VANDIRAYI

**TITLE OF DISSERTATION: FACTORS THAT INFLUENCE HIV STATUS DISCLOSURE
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Signed.....

Date..... JUNE 2018

Address: HSE NO. 401 SHURUGWI Z.B.S

Phone: 0733757640

Email Address: sheltahesther33@gmail.com

DECLARATION FORM

I **Shelter Vandirayi** Reg number **R144306P** declare that this dissertation is the product of my work that it has not been submitted before for any degree or examination in any other university, and that all the sources i have used have been indicated and acknowledged as complete references.

Signed.....

Date...../...../.....

DEDICATION

I wish to dedicate this work to my loving mother, Mrs Vandirayi who struggled with my fees in the course of my academic years and her inspiration, love and support throughout.

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Abstract

When it comes to HIV/AIDS prevention and treatment, there is a growing population that is being overlooked due to a prolonging misconception about HIV/AIDS being a disease of the young adults. The introduction of the highly active antiretroviral therapy has allowed the survival of the elderly after diagnosis. Because of the perception that HIV is a disease of the young adults, HIV disclosure of positive serostatus has become an area of concern among the elderly. It is therefore the aim of this study to focus on the factors that influence disclosure among the elderly. A qualitative study with the application of phenomenological approach was carried out to find out factors that influence disclosure among the elderly. Sample data was obtained from 14 participants aged 50 years and above who attended Shurugwi District Hospital for ART. Using the convenience sampling technique, the researcher was able to select those patients who were easily accessible until sample size was reached. The main findings from the research indicated that fear of stigma was the main reason that hindered the elderly to freely disclose their HIV positive serostatus. Stigma was found to cut across all the interactions in the social lives of these elderly people living with HIV in Shurugwi. Due to fear of stigma, findings from the research highlighted that the elderly used various strategies to cope with a positive HIV serostatus in a stigmatized environment. The researcher used interpretive thematic analysis that allowed coding of findings. Stigma was found to play a major role in hindering disclosure of a positive HIV status among the elderly people in Shurugwi. In order to reduce the negative consequences of disclosure, the general population should be educated about the importance of disclosure so that perceived consequences of disclosure like stigma can be reduced and prevented.

ABBREVIATIONS AND ACRONYMS

HIV	- Human Immuno-deficiency Virus
SSA	- Sub-Saharan Africa
CDC	- Centre for Disease Control.
HAART	- Highly Active Antiretroviral Therapy
ART	-Antiretroviral Therapy
UNFPA	-United Nations Pensions Fund
UNAIDS	- The Joint United Nations Programme on HIV/AIDS
WHO	- World Health Organization
PLWHA	- People Living With HIV/AIDS

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CHAPTER 1

INTRODUCTION

1.1 Introduction to the study

Chapter one is the introductory chapter to the research problem. It basically outlines the background of the study and the research problem. Focus of study is on the factors that influence HIV status disclosure among the elderly living in Shurugwi District. Chapter one, therefore provides an overview of the study, significance of the study, the assumptions and the delimitations of the study. It is the purpose of this research to find out factors influencing disclosure among the elderly. .

1.2 Background of study

With regards to HIV/AIDS counteractive action, there is a developing population that is being disregarded because of a drawing out misguided judgment about HIV being an infection of the young adults (Brennan-Ing, 2017). While it is so, it is estimated that in well developed health care systems almost half of all the people living with HIV/AIDS are 50 years and older. Some countries are expecting this number of the elderly to increase by almost 70% in 2020 (Brennan-Ing, 2017). According to UNAIDS and WHO (2016), among the 40 million people living with HIV/AIDS in the world, approximately 2.8 million are 50 years and older. This has been necessitated by the introduction of highly active antiretroviral therapy (HAART) in the mid 1990s, which has resulted in survival after HIV/AIDS diagnosis (APA, 2017).

The data gathered from industrialized countries on aging with HIV from reflected that HIV epidemic in this segmented age group of 50years and above is increasing. In June 2006, of the 8 % of HIV cases reported in Canada, 12% of the HIV/AIDS patients were 50 years and older (Public Health Agency of Canada, 2006). In Australia, 2006, people over the age of 50 years living with the condition accounted to 14% (National centre in HIV epidemiology and clinical research, 2007) and in the United Kingdom, people living with HIV accounted to 3.8 % (HPA, Communicable Disease Surveillance Centre, 2007).

With all this at hand, HIV/AIDS still remains a major public concern to the health system globally. Sub-Saharan Africa contributes to the global HIV/AIDS burden by 68% of all HIV/AIDS patients (Mishel, Margaret, Anthony, 2011). Research has shown that an estimate of almost 74.000 older adults who are 50 years and above in Sub-Saharan Africa are infected each year (Ndiaye, Zunzunenguni, 2008).

In Zimbabwe particularly, 1.4 million people have been estimated to be living with HIV (ZDHS, 2015). With an HIV prevalence of 14.7%, Zimbabwe was qualified to be on the fifth position of the most HIV affected Sub-Saharan African countries (UNFPA, 2016). In the Midlands Province of Zimbabwe, by district, Shurugwi bears a 17% HIV prevalence of all HIV patients (NAC, 2016).

In the Sub-Saharan Africa, there is a large number of people accessing life-prolonging antiretroviral treatment (ART) and these people are expected to live longer to older age (UNAIDS, 2011). Mathematical model evaluations pinpoints that the quantity of people who are 50 years and older living with HIV has enlarged with an estimated 2.5million in the Sub-Saharan Africa (UNAIDS, 2014). A Gap Report concerning HIV and ageing (Nyamakupa, Gregson et al., 2013) released by UNAIDS expressed that older adults are a group deserted and ageism is partially responsible for neglect among the elderly (UNAIDS, 2014). Hence, there has been an expanded research in the region of maturing and HIV running from treatment results (Mahy, 2014) and anticipation prompting stigma and co-morbidities (Kuteesa and Negin, 2012).

Previous research has it that almost 2/3 of all older people with HIV have experienced stigma due to HIV and age thereby leading to non-disclosure (Branson, 2006). Non-disclosure has led to quite a number of negative outcomes among the elderly. Non-disclosure of HIV serostatus among the elderly is a combination of stigma due to age, sexual orientation, race/ ethnicity, gender identity, relationship status, religion and culture, educational level and awareness of partner's HIV status (Brennan-ing, 2015).

Research has shown that the rates of disclosure differ slightly with age. It seems that younger people are more likely to disclose their HIV status to their sexual partners than the elderly and these older adults are more socially isolated than their younger counterparts (Gaskins, 2006). The reasons why the elderly are likely not to disclose are fear of stigma, fear of blame and rejection,

shame (Bouillon et. al, 2007), loss of social support (Calin et. al, 2007), fear of conflict with partner (Yonah et. al, 2014). Stigma has got negative impact on behaviors and self perceptions of the infected people and this greatly affects individuals hindering them from displaying health seeking behaviors. Stigma can make people less likely to seek an HIV test, less likely to disclose HIV status if they are positive, and more likely to engage in high-risk sexual activities (Effros, Fletcher, Gebo, et al, 2008).

HIV status disclosure hence remains a major barrier in the battle against the spread of HIV/AIDS in Sub-Saharan Africa (Mbwambo et.al, 2005). Studies have indicated how HIV status disclosure have benefited individuals living with HIV/AIDS in different ways including psychological, emotional and material support from family and other group individuals and has likewise given people the flexibility to utilize ARV prescription (Kiula, Damian and Msuya, 2013). HIV transmission occurs between partners including mates, therefore disclosure of status will give appropriate access to care and treatment services in case the partner or spouse is also affected. HIV/AIDS disclosure is very important in that it enables partners to take part in preventative measures and the person who uncovers is probably going to get better help to adapt up to their HIV status and disease (Yonah et. al, 2014).

HIV status disclosure is necessary as it results in the ability to access HIV related services which include ART services (Hosseinzadeh, 2012), education on sexual risk behaviors as well as the importance of disclosure and these are necessary in reduced transmission of HIV from one individual to another (Miller et al, 2007). HIV disclosure increases opportunities for obtaining social support, implementation of HIV risk reduction with partners and also motivates partners to seek voluntary HIV counseling and testing (Gari et al, 2010). The current research focuses on the effects of HIV disclosure among the elderly in Shurugwi.

1.3 Statement of the problem

HIV imposes huge pressure on individuals affected in families. Generally, family members are faced with the demands of looking after the HIV infected individuals. What worsens the impact of HIV is the stigma associated with the condition and the psychological strain of coping with HIV (Khan et. al, 2017). Elderly people living with HIV experience huge stress as a result of the consequences of being HIV positive in old age. Presently, there are several programmes focusing

on HIV infection among young adults and very little is being done for the HIV infected elderly and very few services are available to assist and train them on how to cope with the disease burden. Various researches have been conducted and findings have indicated that the elderly are gradually becoming impacted by HIV disease both as newly infected individuals and as long term survivors of the disease living into older age (Nyaribo, 2015). HIV-related stigma influences the quality of life of all persons with HIV. Research has it that a segmented group of the elderly (50 years and above) are accessing life prolonging antiretroviral drugs at Shurugwi District Hospital. Most of the people living with HIV do not want to transmit the disease and they believe that safer sex practices or disclosure is the appropriate thing they can do. However, these people are hindered by the perception that disclosure is the extremely personal and difficult thing to undertake. The most common way of HIV transmission is through sexual intercourse and this is a taboo with older people and various cultures to talk about these subjects since they can not be talked openly and honestly. Researchers need to be aware of all the powerful psychosocial factors that influence a person's decision to disclose or not to disclose his or her HIV-positive status. Some of these factors include the fear of rejection, stigma, discrimination, possible criminalization, abuse and death (Nyaribo, 2015). Regardless of these fears and barriers, WHO (2014) and the centre for disease control and prevention CDC) emphasized the importance of HIV status disclosure. Disclosure of HIV /AIDS status to partners is associated with less concern and increased social support among many individuals. More so, HIV status disclosure may lead to enhanced access to HIV prevention and treatment programs, increased opportunities for risk reduction and increased opportunities to plan for the future of the family. This study therefore aims at exploring the consequences and factors affecting disclosing HIV/AIDS status among the elderly in Shurugwi district.

1.4 Purpose of the study

This study intends to find out the factors influencing HIV status disclosure among the elderly. The study seeks to unveil the barriers to disclosure among the elderly.

1.5 Significance of the study

The completion of this research project provides scientific evidence regarding the factors which influence a person's decision to disclose his/her HIV status, particularly the elderly. Its aim is to show that being HIV positive does not at all call for segregation, discrimination, stigmatization

or rejection. It also aims at widening research in the health sector, student (researcher) as well as the elderly people living with HIV/AIDS by imparting them with adequate knowledge about HIV/AIDS.

1.5.1 Student

Having carried out this research project, the researcher gained experience on carrying out detailed research hence this serves as a good foundation for future work. The research project being a partial fulfillment of the Bsc Honors degree in Psychology, the researcher attained her academic objective. In addition, the researcher will have a chance to apply the research techniques learnt as well as gaining experience to the real Health Sector.

1.5.2 Health Care Professionals

The information researched is necessary for assisting health care professionals in understanding the complex elements of disclosure. Disclosure is an important prevention goal emphasized by WHO in their protocols for HIV testing and counseling (Medley et al, 2004). The study also emphasized to help the Ministry of Health and other NGOs in coming up with strategies that criminalize any offence against people particularly the elderly living with HIV and also policies that emphasize more on the need for psychosocial support for the elderly living positive.

1.5.3 The elderly living with HIV

The research preserves a positives function to the elderly living with HIV in unveiling the effectiveness of disclosure of HIV status to their partners, children or members of the family as well as the society at large.

1.6 Research questions

1. What are the factors that influence HIV disclosure among the elderly?
2. What are the consequences of HIV disclosure among the elderly?
3. What are the strategies used by the elderly as they conceal their HIV status?

1.7 Limitations

The research was limited by language barrier. The researcher had to assist every participant with the questions asked as there was need for translation from English to shona and it was taking a lot of time. Some of the elderly participants felt embarrassed to discuss about HIV and HIV transmission therefore failed to convey much information about their experiences.

1.8 Delimitations

The research was conducted in Shurugwi District, Zimbabwe on clients served at Makarima District Hospital, Shurugwi. Focus of study was on the factors affecting HIV disclosure among the elderly of 50 years of age and above in Shurugwi District.

1.9 Assumptions

The researcher assumed that the respondents have knowledge about HIV/AIDS and how it can be transmitted from one host to another. The researcher also assumed that the respondents provided accurate and correct information and that the data from respondents was adequate to deduce findings and conclusions about HIV disclosure among the elderly. The researcher also assumed that disclosure has positive and negative impacts on the lives of both the affected and the unaffected.

1.10 Definition of key terms

1.10.1 Disclosure

It is an act of revealing something that has been hidden or making known something that has been kept a secret. According to Eustace and Ilagan, (2010), HIV disclosure is defined as a complex and multifaceted process of making a voluntary or involuntary decision about whom to inform about one's serostatus, why, when, where and how.

1.10.2 Elderly

Elderly individuals are portrayed as people over 60 years who are typically described by people beyond 60 years old, described by defenselessness, for example, psychological instability, weakness, deficient instruction, neediness, absence of social help and broken family (Huber et. al, 2008). In this study an elderly is defined as a person above 50 years infected with HIV.

1.10.3 HIV

Human Immuno-deficiency Virus is a disease that is passed from one person to another through risky sexual behavior, or through mother to child transmission (Center on Aging studies, 2007).

1.10.4 HIV-related stigma

HIV-related stigma and discrimination is prejudice, negative attitudes and abuse directed at people living with HIV and AIDS (UNAIDS, 2015)

1.11 Chapter Summary

Chapter one is the introduction to the research and basically outlines the content of the chapter that is the background of study, statement of the problem, purpose of the study, significance of the study, statement of the problem, purpose of the study, significance of the study, delimitations and the limitations. Chapter one also provides the research questions and assumptions underlying the study. HIV disclosure and the associated processes and outcomes influence a person's decision to disclose or not to disclose their status as stated above. A better view of the concept of disclosure is very essential in order to meet and support the possible requirements of people living with HIV/AIDS. Chapter two focuses on the literature review underlying the study. Chapter 1 gives a brief emphasis on the area of study. It also highlights the significance of the study, the area in which this research can be of help.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter analyses previous research findings on this area of study. It focuses on the ideas, opinions and views of other researchers on this project under study. In so doing, the study describes, summarizes, evaluates clarify and integrates the contents of other scholars. Literature review is a critical study of what other scholars have done on a particular subject (Leedy, 1993). Afolabi (1992) posits that the literature review is so important that its omission represents a void or absence of a major element in research. The major reasons for spending time and effort on literature review is that it helps in identifying gaps in the literature and provides the intellectual context of researcher's work (Bourner, 1996). The literature review was undertaken to determine the factors that HIV/AIDS disclosure among the elderly. The study made use of textbooks, journals and other various sources for reference of information.

2.2 HIV status disclosure among the elderly

HIV status disclosure is characterized as a compound and multifaceted procedure of settling on a purposeful or programmed decision about whom to educate about one's serostatus, why, when, where and how (Eustace and Ilagan, 2010). HIV status disclosure remains a noteworthy deterrent in the battle against the spread of HIV/AIDS in Sub-Saharan Africa as it is associated with some negative outcomes (Mbwambo et.al, 2005). HIV status disclosure is a critical aspect of optional HIV counteractive with benefits for both the tainted individual and society everywhere as it draws in social help and lessens secondary HIV prevention with benefits for both the infected individual and society at large as it attracts social support and reduces HIV transmission risk practices (Greef et al, 2008).

HIV status disclosure is not a one time occasion or an absolute; rather it is a developing procedure that differs by setting and accomplice's response (Chaudior, Fisher and Simoni, 2011). A few men are motivated to uncover their HIV-constructive serostatus because of feeling personally responsible of their accomplices' wellbeing or with an end goal to maintain a strategic distance from sentiments of blame. HIV-constructive individuals over 50 years will probably uncover to primary accomplices than to casual accomplices, (Simoni and Pantalone, 2005).

Chaudoir, Fisher, and Simoni (2011) propose that the choice to unveil one's disclosure is frequently drawn closer from a quest for positive results, or from the avoidance of negative results affecting the disclosure procedure in an unexpected way. A study on safer sex behaviors was carried out in Kenya and it revealed that non-disclosure among partners was associated with unsafe sex practices (Medley et al, 2009). Disclosure to family involves risks such as negative emotional reactions, fear of stigmatizing children (Wabwire et al, 2009), fear of abandonment and fear of being disowned.

A research carried out in Ethiopia indicated that individuals who reported to have not disclosed due to fear of partner's reaction accounted to 54% (Medley et al, 2009). However, among the individuals who disclosed, 5% reported to have faced negative reaction from partner Wabwire-Mangen et al, 2009). The research concluded that although the majority of participants disclosed their test results, their lack of disclosure resulted in a narrow potential to engage in preventive behaviors and to access support (Kumar et al, 2006). Disclosure is useful when it urges individuals to get to HIV prevention and care benefits as it advances more secure sex practices, avoid new contaminations to partners, increase social help and decrease discouragement and unsafe when it brings unfriendly results, for example, disgrace, segregation, dismissal, separate, fault, and abandonment, among others (Kumar et al, 2006) and these are significant deterrents of disclosure that lessen the pace of HIV anticipation.

Regardless of the benefits mentioned above, the disclosure rates in some developing countries remain low as it ranges from 16.7% to 86% (United Nations, 2012). Some countries allow disclosure to be done by the patient himself/herself and the patient decides to tell the person he/she prefers. However, in some countries, health care providers are the ones who make decisions on who to disclose to; the patient first or the patient's family member (Nyaribo, 2015). It then becomes the family's decision whether or not to tell the patient the truth or to hide it for the sake of patient's best interests. Be that as it may, disregarding the great expectation of including relatives in HIV exposure, in a few families, disclosure has brought about segregation and mental pressure. Women suffer more from such negative consequences than men (Schoepf, 2010). HIV positive status exposure is an extremely delicate issue since one can not know the result of their disclosure (Kumar et al, 2006).

Individuals infected by HIV need to understand the advantages of disclosure against harm before revealing their status to other people. This reality gives a comprehension of barriers and opportunities of HIV status disclosure and associated factors among people living with HIV/AIDS who are attending care and treatment centers.

Research findings indicate that disclosure rates vary with age. It seems that young adults disclose their HIV status more than the elderly and these elderly people are more socially alienated than the young adults (Gaskins, 2006). The reasons why the elderly are likely not to disclose are fear of being stigmatized, fear of blame and rejection, shame (Bouillon et. al, 2007), loss of social support (Calin et. al, 2007), fear of conflict with partner (Yonah et. al, 2014). Stigma can make individuals more averse to look for a HIV test, less inclined to unveil HIV status in the event that they are sure, and more prone to participate in high-chance sexual exercises (Effros, Fletcher, Gebo, et al, 2008). Implicit ageism is partially responsible for neglect among the elderly living with HIV because they are a group that has been overlooked. Therefore, with such a perception, this group chooses to conceal their matter to themselves (APA, 2015).

The health's view of point on HIV disclosure has been advocated for because of its interventions in reducing HIV transmission especially from one sexual partner to another and allows partners to engage in preventive behaviors such as HIV testing and condom use (Deribe et. al, 2006). Similarly, support from groups of people living with (PLWHA) was also found out to improve disclosure of HIV status to members of the family (Paxton, 2005). From the individual's point of view, studies indicate that the reasons for disclosure can be classified in two that is self-focused and other-focused (Chandra et al, 2003). Self-focused disclosure includes the requirement for social help, which is mostly the reason for disclosing to family members (Chesney et al, 2005); decline of physical health and the need to access medical care and treatment (Leask et al, 2006); the need for spiritual support, which often leads to disclosing to pastors (Miller et al, 2007); the nature of the relationship, especially with one's spouse (King, Katuntu et al, 2008). Other-focused are those that decide to or not to disclose to individuals they also believe to be HIV positive (Rice and Comulada, 2009); they are concerned about how the disclosure target will respond to the information (Miller et al, 2007); and they are filled with desire to protect others from contracting HIV (Medley and Garcio-Moreno, 2005).

HIV/AIDS disclosure is crucial in that it allows partners to get involved in preventative measures and the one who discloses is likely to access better support to cope up with their HIV status and illness (Yonah et al, 2014). The positive effects of disclosure include the ability to access HIV related services (Miller et al, 2007) and ART services (Hosseinzadeh, 2012). HIV disclosure increases opportunities for acquiring social help, implementation of HIV risk practices reduction with partners and also motivates partners to seek voluntary HIV counseling and testing (Gari et al, 2010). Disclosure also improves emotional support and reduces stress. Decisions not to disclose can also lead to considerable stress and enhance social isolation (Nyaribo, 2015).

2.3 Factors influencing HIV disclosure among the elderly

Studies have shown that there are a number of factors which influence disclosure of HIV and these include age, gender, religion and culture, level of education, relationship status amongst other factors. These are social and behavioral factors associated with aging.

2.3.1 Age

Rates of HIV status disclosure vary slightly with the age of the infected individual. Studies have shown that young adults are likely to disclose their HIV status than the elderly who are in their 50s (Kadowa and Nuwaha, 2009). Mathematical models estimated that approximately 74.000 older adults over 50 years in the Sub-Saharan Africa are infected each year (Ndiaye et al, 2008). A UNAIDS report in 2012 stated that the rate of new HIV infections among people of 50 years and over was higher than previously thought as it was associated with diseases of aging. Previous literature has pointed out that older age is associated with increased HIV stigma and less disclosure among the elderly (Charles, 2006).

2.3.2 Gender

Research shows that gender plays a very significant role on disclosure globally. It determines whether and individual should or should not disclose his or her positive HIV status. Studies have indicated that females tend to experience more serious consequences of disclosure such as physical and sexual assault due to disclosure of a positive HIV status (Brou et al, 2007). The relationship between gender and HIV/AIDS becomes significant as it is influenced by gender inequality and discrimination. Research has it that non-disclosure by reason of gender made men to be concerned about their partner's worry and revelation of their own unfaithfulness (Mucheto

et al, 2009). Gender is a social construct and it relates to roles and responsibilities of male and female (Turmen, 2008). HIV disclosure has been associated with serious effects on both men and women (Akpa, Adeolu-Olaya et.al, 2011). Anxiety about disclosure may affect both partners as they may fear abandonment and rejection by their families. In other societies, it is not considered mannish to access medical care services especially in old age (Aganaba, 2011). In such societies, the value of women's health is negligible due to power inequalities which may lead to insubordination of women (Peacock, Jewks & Msimang, 2008). HIV disclosure among old women may be affected by fear of partner violence, fear of the impact it has on family life (Daniel & Hutson, 2017). The gender-related fears of a positive HIV status disclosure impose a burden on elderly women living with HIV, particularly women who are involved in violent relationships. The impact of gender roles and relations influence the rate of disclosure amongst the elderly. Gender-based beliefs influence the capability of females and males to behave in ways that correspond to their risk perception of HIV (Anderson et al, 2007).

Sociocultural factors, behavioural factors and psychological factors contribute to disclosure. These factors make an individual more or less vulnerable to infection and the elderly are no exception (Falola at. al, 2007; Scott, 2009). There is existing evidence that social construction of man hood suggests that man's health is affected by risky behaviours indirectly thereby increasing the vulnerability of their female partners to sexually transmitted diseases including HIV (Peacock et al, 2008). Studies have shown that patriarchy perpetuates male domination and superiority and results in female inferiority and submission. This brings in to conclusion that women have to be always directed and protected by their male counterparts as they are perpetually depending on men (Baloyi, 2010). From this perspective, African cultures view women as sexual objects and men are encouraged to view women from this dimension (Baloyi, 2009). Baloyi (2010) further concludes that the consequences that follow these male risky behaviours however are imposed on women because of the African cultures.

These leading belief systems of masculinity urge men to exhibit sexual capability by having numerous partners and sexual qualification to ladies, subsequently adding to men's dangerous sexual practices (Stern, Rau & Cooper 2014). Multiple associations are permitted and even supported for men, while ladies are required to be monogamous and unquestioning of their partner's conduct and this encourages the spreading of the infection in South Africa (Mswela,

2009). According to Van-Staden and Badenhorst (2009), male dominance influences sexual behaviours that put females at risky places and this also applies to the cultural practices that view male masculinity which increases the male risk of contracting HIV infection. The same gender relations and roles that influence and enhance women's vulnerability to HIV also increase risks for men.

An examination that was completed in Botswana demonstrated that elderly men would probably have sexual partners who were ten years younger than they are and were at more serious dangers of being tainted with the infection (Keetile, 2014). Similar men at that point taint their elderly female partners subsequent to having unprotected sex with more youthful females and this made disclosure with respect to elderly men troublesome (Smith, 2017).

Studies also show that South African men are also much less likely than women to present for HIV testing and therefore less likely to be aware of their status. This unwillingness for Voluntary testing and counselling (VCT) imperils their female partners, who may be less likely to use HIV prevention methods if unaware that their partners are HIV-positive (Lekalakala-Mokgele, 2016).

2.3.3 Relationship Status

Relationship status of an individual also influences the ability of an individual to disclose or not to disclose (Philips et. al, 2009). Research has it that it is not easy to just disclose to your partner about one's HIV status. The number of an individual has influences the rates of disclosure (Smith et. al, 2017). As the number of partners increase, the rate of disclosure is likely to decrease especially in polygamous situations (Gari, Markos & Habte, 2011). Disclosure rates are higher to steady partners in comparison to casual partners (Chaudor et al, 2011). The rate of disclosure is significantly affected by the stage of the virus (O'brein et al, 2008) and in old age, the virus would have reached higher levels/stages. Women who are married are likely to disclose than women in cohabiting relationships (Greig et al, 2008). Individuals with multiple sex partners are less likely to disclose their HIV status to their partners (Eustace and Ilagan, 2010).

2.3.4 Religion

Religion aspects have also been considered to contribute to individual's attitudes about HIV status disclosure, HIV and ART (John, Watt and Ostermann, 2008). Studies show that there is a very strong belief concerning people with HIV that they have done something wrong and

probably receiving a punishment from God especially in old age (Smith et al, 2017). A study conducted by Yamanaka et al (2008) amongst 400 parishioners showed that quite a number of them pointed that prayer could heal HIV, although some of the believers still preferred the decision of medical treatment. The research found out that religion and perceived fear of stigmatization are closely related and the majority of the sample felt the need for disclosure of their HIV positive status to their partners and their families. This was just an intention to disclose not actual disclosure. Most of the believers in their old age were leaders in the Parish and felt it embarrassing to disclose their HIV status to the church (Yamanaka et al, 2008).

A research in Nigeria indicated that Muslims are stigmatized more often if their partners die due to HIV/AIDS across all age groups (Akpa et al, 2011). Muslim culture prevents women from attending HIV/AIDS clinics as it is something uncommon to them (Akpa et al, 2011). The cultural differences in countries like India and Africa have been described to allow disclosure mostly to family members only, whereas in the West, disclosure is more often done to friends (Eustace and Ilagan, 2011).

2.3.5 Culture

Cultural norms are other aspects of concern in the society. In some situations, promiscuity is considered acceptable in men as it is associated with the encouragement to drink alcohol which results in high risk sexual behavior (Nkosi et al, 2015). Women value hegemonic masculine norms (Quayle, 2015). For example, some women approved the idea that men can engage in extramarital sex once they experience menopause. Baloyi (2009) notes that this a social structure intended for women in African tradition, where sexual intercourse is not likely to be a long-life practice for women when they enter menopause, and that they are no longer well thought-out suitable to have sex. Some sociocultural factors in developing countries put up with promiscuity among men (Poku & Boesten, 2016).

2.3.5 Educational Level

There are aspects to be put into consideration when attempting to determine how educational level affects disclosure. One point to note is the educational level that is academic achievement level in school of an individual and the second one is the knowledge one has concerning HIV/AIDS (Eustace and Ilagan, 2011). In rural areas, stigma is higher due to lack of education and lower economic status (Darlington & Hutson, 2017)

Studies show that the most uneducated group concerning HIV/AIDS is that of older people especially those from rural backgrounds, (NAC, 2016). Male participants of a completed study in a small rural area in Enugu State, Nigeria, claimed that unawareness about HIV made disclosure difficult and even criticized an individual who stated that people will look down upon you if they find out of your HIV status (Akpa et al, 2011). These men also stated that knowledge about HIV/AIDS and treatment options is urgently required to address the importance of disclosure (Gaskins, 2006). Lack of knowledge concerning HIV/AIDS and disclosure is directly linked to the educational level of an individual and may be related to cultural practices. Cultured elderly people overlook the issue of HIV and this is associated by the educational level of this group (Medley et al, 2005). Many cultures rate lack of knowledge concerning sexual interaction as a characteristic of femininity thereby affecting their education (Millet, 2016). In Philippines, research has it that the majority of people have a heard of the disease, but very few have considerable knowledge about the infection, mostly in the old age group (Turmen, 2005). Individuals with higher level of education are more likely to disclose their HIV status which would result in safer sex practices than those with basic education or those who are illiterate (Deribe et al, 2005). Furthermore, the choice to start treatment was directly related to educational level. Studies show that the higher the educational level, the more likely the individual prefers to start treatment (Zou et al, 2008).

2.3.6 Awareness of partner's status

HIV disclosure among the elderly is also influenced by an individual's awareness of partner's status. It is also influenced by partner serostatus, length of HIV-diagnosis, comfort with one's sexual identity, knowledge of CD4 count, knowledge of viral load (Rosser et al., 2008). Reasons for non disclosure when one is unaware of partners status are fear of rejection, discrimination, HIV stigma, the risk of violence, and the loss of privacy (Relf et al., 2009), and internalized stigma (Overstreet, 2013), anxiety, and shame. The rates of disclosure are affected by awareness of partner's status and most studies have shown that individuals are less likely to disclose their HIV status if they are unaware of their partner's status (O'Brein at al, 2007). Knowledge about partner's status empowers one to disclose and make better choices on sexual behavior such as abstinence and condom use but challenges arise between discordant couples (ZDHIS, 2008). When one partner is tested negative and the other positive, research has it that chances of disclosure on the part of the one who tested positive is likely to be low (Deribe et al, 2007). A

study conducted by King et al (2007) proved that the rates of disclosure are high among married couples who are fully aware of each other's status. Women are more likely to disclose to their HIV positive partners than those who do not know their partner's status (Gari et al, 2010).

2.4 Consequences of HIV disclosure among the elderly

Consequences of HIV disclosure include stigma and discrimination, blame and rejection, shame, abuse and violence, loss of family support and financial support. These are barriers that result in risk sexual behaviors which may necessitates HIV transmission as well as poor adherence to treatment (Medley, 2009). This section explains why there is little or no disclosure among the elderly.

2.4.1 Stigma and discrimination

HIV-related stigma is characterized as partiality marking down, defaming and segregation aimed at people apparent to have HIV/AIDS (Herek et al, 1998). HIV among the elderly remains an exceedingly criticized condition around the world (Brennan & Karpiak 2010). The dread of stigma contrarily influences the manner by which people and families secure themselves, look for care and treatment and offer help to those influenced with HIV which may likewise expand helplessness and increase vulnerability to HIV (CDC, USAID and WHO, 2012). Stigma manifests in various ways which incorporate enacted, disguised and anticipated stigma (Earnshaw and Chaudior, 2009)

Enacted stigma is a stigma experienced by an individual from others. It also includes the associated prejudice and discrimination coming from others towards an individual. Internalized stigma refers to internally accepted and approved beliefs and attributes concerning individuals living with HIV. Anticipated stigma means the extent to which a person living with HIV expects to experience enacted stigma (Rueda et al., 2012). These components of stigma have got different impacts on individuals depending on social network, gender and sexual orientation (Akpa et al, 2010). There is greater importance to understand these multifaceted components of stigma and their different impacts on the elderly living with HIV so that both social and individual interventions may be adopted (Gaskins, 2006). Older people living with HIV often internalize stigma in thoughts of embarrassment, guilt, anger, fear, and isolation leading to social disintegration (Akpa et al, 2010). Many face social avoidance, the real or perceived loss of

friends, and the sense that people are uncomfortable being around them due to their HIV disease (Rueda et al, 2012).

Enacted stigma has got serious impact on the psychological well-being of older adults living with HIV. It negatively affects their self esteem and psychological well being (Psaros et al, 2012). A study by Psaros et al (2012) showed that positive older women experienced internalized stigma leading to the belief that no one would want an intimate relationship with them. A study by Simbayi et al (2007) showed that almost 30% of people in South Africa admitted to be suffering from depression due to HIV related stigma and of the 30% consisted elderly men and women.

The elderly who experience stigma end up engaging in stigma management strategies which would be maladaptive (Foster and Gaskins) like non disclosure of HIV status. They choose not to seek treatment in the areas they live. A study in Canada on older adults living with HIV showed that they hide their status from their families, adult children in order to avoid anticipated stigma (Wallach & Brotman, 2012). However, limiting disclosure because of anticipated stigma resulted in social support limitation which saved as a protective factor against stigma and other HIV related effects (Groves et al 2010).

2.4.2 Shame

A study by Deribe et al (2010) shows that to older women, shame was one of the major main reasons why they did not like disclosing their HIV status. He further propounded that women made remarks of how shameful it is to be HIV positive because it is contracted through sexual intercourse and sex was a taboo for some Africans in old age. It is a shame and shame kills. According to this study, Deribe et al (2006) notes that a health expert made a similar reference to shame as an important issue in the decision not to disclose mostly in older people.

2.4.3 Blame and rejection

Blame and rejection influence disclosure among the elderly according to Simbayi et al (2006). They reported that individuals often attempt to conceal their HIV positive status due to negative responses from others. Separation and divorce have been documented as important factor hindering disclosure. Infected individuals fear blame of having multiple sexual partners especially in intimate relationships where one partner tested positive and clearly knew that

his/her partner had tested negative. Individuals however, feared losing their sexual partners as a result of the issue.

2.4.4 Loss of family support

HIV status disclosure results in negative outcomes that make individuals choose to conceal their status from community, members of the family, friends and sexual partners. Stigma, discrimination and divorce following HIV sero-status disclosure was reported by few participants in the study carried out by Yonah et al (2014). This signifies the importance of increasing awareness in communities to alleviate stigma attached to HIV infection. Mucheto et al (2009) reported women who believed disclosure would cause divorce were less likely to disclose in a study conducted among HIV infected women attending antenatal and postnatal clinic in Zimbabwe. Couple counselling may be a useful strategy to mitigate spousal rejection and enhance serostatus disclosure in communities (Norman et al, 2007). Deribe *et al.* (2010) in their study found that fear to reveal infidelity among partners made men to less likely to disclose their status to women. However, the decision not to disclose has got a negative impact on the prevention of HIV transmission among individuals (Bott & Obermeyer, 2013).

2.4.5 Loss for financial support

Disclosure is made impossible on the part of the woman more because of the imbalance of power between men and women who translates it into economic dependency for women (Moallar and Kapoor, 2009). Because of poverty which has been reported to be a driving force of HIV transmission among women (Joint United Nations Programmes, 2012), women's financial autonomy constrains them in risky behaviors such as non-disclosure (Dworkin & Blankership, 2009).

Financial stability of a partner determines whether he or she should disclose their HIV positive status. These various aspects may include partner support whereby they support each other financially and may not depend on well-wishers while the contrary, financially unstable individuals may tend to depend on well-wishers for financial support which may lead to non-disclosure (Nyaribo, 2015). The latter will tend to disclose in order to obtain the much needed financial support. The power imbalance between men and women also translates into economic dependence of women (Kenyon et al. 2010).

2.5 Strategies used to conceal positive HIV status among the elderly

HIV non-disclosure has caused the elderly to make use of coping strategies that help them to conceal their status to themselves (Cahil & Valadez, 2013). Coping strategies are a set of emotional and action-based strategies aimed at reducing the negative consequences of stress that emanates from a stigmatized environment (Pearlin & Bierman, 2013). Secrecy, social isolation and mastery were some of the strategies that studies have indicated to be used by the elderly to conceal their HIV positive status. Apart from studies highlighting the negative impact of stigma related to HIV among the elderly, some of the studies have identified useful mechanisms that may serve as measures of protection against stigma and all its components (Cahil & Valadez, 2013). These characteristics can be intrapersonal, interpersonal and social.

2.5.1 Mastery

One component that is a defensive factor against stigma is dominance or mastery, which is characterized as the degree to which an individual trusts that their life's conditions are under their own control (Pearlin and Schooler, 1978). A current report by Emlet and Ontario (2013) in Toronto showed that expanded authority was related with diminished stigma. In addition, mastery was connected with diminishing stigma over every one of the three sorts of stigma ie (instituted, internalized and anticipated). Different investigations have discovered dominance to intercede the impacts of stigma in HIV-positive populations (Rueda et al, 2012).

2.5.2 Concealment from 'relevant others' and outsiders.

Elmen (2006) described how HIV positive individuals concealed their HIV status from those they do not want to disclose to mainly close partners who lived away from them. He carried out a study in which he interviewed individuals in a clinical setting. By not disclosing the participants claimed to feel stronger and believed that they could manage their illness. They only had the burden of keeping the secrecy and at times feelings of guilt. 3 male participants of the age 50 years and above cohabiting with their partners claimed that it was not necessary to disclose a positive HIV status. Elmen (2006) notes that some of the participants did not disclose because of their concerns for the emotional stability of their 'relevant others' especially to their adults children.

Castle (2010) reported that concealment was the best strategy the older people living with HIV thought they could use in coping with HIV disease and treatment. In his study, some participants

made it clear that they had been living with HIV for more than 20 years and had not disclosed to anyone. Participants in Castle's study explained how they used different strategies in preventing others to know about their status.

2.5.3 Social isolation and distancing

According to Nachege et al, (2005) hiding of the positive HIV status from outsiders was better by distancing oneself and within the family by social disengagement which may be associated with ageism. A study carried out by Hosseinzadeh et al (2012) concluded that when the elderly attended social gatherings, religious gatherings or cultural gatherings they did not interact with others. One of the elderly participants in the study reported that she goes to church but had never been able to tell even the pastor because she feared to be humiliated and looked at as if she had sinned. Another participant explained that she did not want to mix with others because of HIV that lived in her and felt that everyone could read it on her face. Farther study on this matter showed that these people preferred talking to doctors and distance themselves from everyone who did not know about their HIV positive status.

2.6 Theoretical framework

The researcher employed socio-cognitive theory by Goffman (1963) in the study.

2.6.1 Socio-cognitive Approach

Socio-cognitive approach is a theory propounded by Goffman (1963). Goffman's decision to theorize stigma has been modified and extended to a level of knowing how individuals construct categories and link these categories to stereotyped beliefs (Parker and Aggelton, 2003). Socio-cognitive theory focuses on the origins of stigma in the cognition of humans, the negative consequences of these individual perceptions on social interactions as well as the perceptions of individuals. (Fiske, 1998). In HIV/AIDS, this socio-cognitive framework constrains the concept of HIV stigma to an examination of how PLWHAs are labeled and stereotyped by the public, based on their incorrect beliefs and attitudes (Oliver, 1992). It also focuses on the specific emotions and cognition of People Living with HIV. This, in turn, limits the extent of stigma reduction interventions to strategies that might increase the empathy and selflessness towards as well as reduce the anxiety and fear of PLWHAs among the general population. Individual based interventions to assist people living with HIV are also needed to cope with perceived or

experienced stigma. These approaches are important, but they eliminate a thorough consideration of structural aspects of stigma; the dynamic social, economic and political processes that concurrently produce and intensify stigma and discrimination (Link and Phelan, 2001).

2.7 Knowledge gap

There are presently several programmes that are being carried out to address HIV infection in young people. However, very little is done for the elderly who are infected with HIV and very few services are available to assist and train them on how to cope with the disease burden. The area under study has been researched in South Africa, Tanzania, Uganda, USA, and Ethiopia only to mention and study has been focusing on HIV disclosure among young adults living with HIV as well as how stigma affects young adults living positive to HIV. However, little has been put forward on the elderly which is the focus of this study, to bring out issues that affect disclosure among the elderly of 50 years and above.

2.8 Chapter summary

Chapter 2 focused on literature review by other scholars concerning factors that result in the individual's unwillingness to disclose, consequences of disclosure as well as coping strategies that can be used as a way of dealing with the stress of the consequences of disclosure. Factors like age, gender, awareness of partners' status, relationship status, educational level and religion and culture were looked into. More so, literature on consequences of disclosure was highlighted and these include stigma and discrimination, loss of family support, loss of financial support, abuse and violence. The research has shown that HIV disclosure to other individuals has a meandering but exact impact on the transmission of the virus too. The reason for this is that, in most instances, the infected individual is unable to negotiate for safer sex methods, access treatment due to fear of stigma, discrimination or fear of losing social network and support. An improved understanding may support the evaluation of the current programs which advocate for disclosure and then adapt these to further improve the disclosure rates of the elderly with HIV/AIDS.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This area clarifies how the research was completed. It takes a look at the research design and instruments that were utilized for information gathering. In other words, the researcher talked about the diverse strategies utilized as a part of data gathering and the research design undertaken. The researcher made utilization of information gathered through interviews. The instruments utilized are so vital to guarantee the reliability and validity. Research methodology alludes to the procedure or plan for leading the determinations of the investigation (Burns and Grove, 2009). Therefore, chapter 3 centers around the research methodology of the research.

3.2 Research approach/paradigm

Research paradigm is a guideline that points one to decision making and carry out a research. A paradigm can be characterized by reality (ontology), how we know something (epistemology) and how we go out finding something (methodology), (Franklin, 2012). In the course of the study, the researcher used qualitative research paradigm. A qualitative research is an interpretive naturalistic way to deal with the world (Denzin and Lincoln, 2005). The researcher executed qualitative approach since it enables one to think about things in their characteristic setting, endeavoring to understand or interpreted phenomena regarding the implications individuals convey to them. While applying a subjective research approach, clarification is put on the characteristic setting and the perspectives of the examination members.

3.3 Research design

A research design is a ground breaking strategy that determines the techniques and systems for gathering and investigating required data (Zikmund, 1994). In this research project, a phenomenological design was utilized to direct the exploration of the study since it focuses on the subjective encounters, social observations and investigation of occasions and phenomena by people. A phenomenological study design was used in this research to determine the factors that affect HIV disclosure among the elderly. Phenomenological research design is a descriptive design that analyzes human encounters through the portrayals given by the general population included. These encounters are called lived encounters (Donalek, 2004). According to Creswell

(1998), sample size for phenomenological design requires at least 6 participants. However, final sample size is determined by data saturation.

3.4 Targeted Population

The targeted population for this study was HIV infected elderly people (50years+) who attended Shurugwi District Hospital for medication (antiretroviral therapy). These people come for reveals at Shurugwi district hospitals.

3.5 Sampling procedure

The researcher implemented a non-probability sampling approach. Non-Probability sampling is selecting small information rich units without randomization, (Denzin and Lincoln, 2005). The researcher implemented non-probability sampling because it uses subjective judgment and utilizes convenient selection of units from the population (Denzin and Lincoln, 2005). In this study, a non-probability sampling technique used was convenience sampling. With convenience sampling technique, the researcher selected those patients who were easily accessible until the sample reached the desired size. The sample was composed of conveniently accessible persons who contributed to the research. Through the Convenience non probability approach, the researcher was able to choose a setting, the kind of a group required for the study and/or individuals that were conveniently available and willing to participate in the study.

3.6 Research instruments

The researcher made use of a semi-structured questionnaire to find out the factors that influence the decision to disclose one's HIV status. The researcher made sure that the questionnaire was skillfully designed in order to make it easier for participants to answer the asked questions. A poorly designed questionnaire would result in participants providing irrelevant and sometimes deceptive data for the researcher which would make analysis difficult. The researcher made sure that the well designed questionnaire would stimulate respondents to provide most favorable responses, eradicate and reduce errors associated with the gathering of data and consequently enhancing the quality of the research findings. Interviews were conducted amongst the selected samples in order to get information on the lived experiences of aging with HIV amongst the elderly.

3.7 Data collection

The researcher was given a data collection letter by the MSU department of Psychology which was directed to Shurugwi District Hospital to allow the researcher to collect data. A semi-structured questionnaire was used on the research. The researcher helped the participants when required, particularly when the respondent had dialect issue or know-how issues and had any inquiries related with the questionnaire.

3.8 Data analysis

Data analysis refers to a process of scientifically applying logical techniques to describe and highlight as well as evaluate data (Shamoo and Resnik, 2003). The researcher employed thematic analysis. Thematic analysis refers to narrative data whereby resultant themes were identified from the collected data (Denzin and Lincoln, 2005). Interpretive analysis was used in the analysis of data. The researcher employed thematic analysis because it is usable for qualitative study. Thematic analysis helped the researcher to come up with themes that allowed further subthemes through coding of findings which, however, were suitable for the study.

3.9 Ethical considerations

Ethical standards are essential whenever human subjects are involved in a study (Creswell, 2003). Individuals who volunteer to participate in a study should be protected and offered high level of consent (Cresswell, 2009). Breaches can cause serious limitation in the future of researchers to collect reliable and useful data as they can be limited to access the data collected by others (Cohen, Manion and Morrison, 2000). The researcher had to implement ethical principles in order to make sure that participants felt secure so that they felt free to convey information that would assist in the research. Ethical principles of beneficence, informed consent, privacy and confidentiality were used to guide the research. The interviews were led in a private room inside the O.I department at Shurugwi District Hospital.

3.9.1 Beneficence

This is an act of charity, mercy and kindness with a strong sense of doing well to others (Beachamp and Childress, 2001). It is an action that is done to benefit others, basically to prevent or remove or to simply improve the situation of others (Pantilat, 2008). Due to the sensitivity of disclosing one's HIV status, a counseling service was provided for participants who became

emotional during information conveying. Support was provided to the client who desired to discuss various aspects of the conditions.

3.9.2 Informed consent

Informed consent was utilized before the questionnaire was looked into and individual participants had the privilege to decline participation or to pull back from the research during information gathering. The researcher clarified the potential dangers and advantages of the participation and emphasized on the intentional idea of participation in the study and individual ability to stop the interview whenever they felt they could not continue or not to answer particular questions.

3.9.3 Confidentiality

Confidentiality is the assurance that individual data is protected and kept safe. It implies the keeping of a client's sensitive information among the researcher and the client, and not telling others including associates, companions, and family. Standard safety measures were attempted to guarantee secrecy of information; no distinguishing information was gathered or recorded apart from the consent statement. Participants were transparently guaranteed of the disposal of gathered data after scholarly utilization.

3.9.4 Privacy

The researcher used privacy in the process of data collection in order to make sure that participants felt comfortable in airing out their subjective views concerning their lived experiences. A one on one interview was carried out in a clear room so that individuals could feel comfortable to release more data.

3.10 Chapter summary

Chapter three provided the research methodology that was used to conduct the research. It looks at the research approach, the research design, the targeted population, the sample and the sampling techniques used in conducting the research. It also looks at the research instrument that was used in the research. It also looks at the ethical considerations implemented in the study that to make the participants feel comfortable to speak out the required information for the study. Basically, this chapter provides the research methodology of the study.

CHAPTER 4

DATA PRESENTATION AND DATA ANALYSIS

4.1 Introduction

This chapter presents the findings from data collected through interviews. Analysis of the data collected, presentation and discussion of the findings in relation to the aim of the study are presented in this chapter. This chapter covered background information, experiences of knowing HIV positive status, factors affecting disclosure, the outcomes of disclosure and coping strategies used in concealment of HIV positive serostatus as well as coping within a stressful environment after disclosure among the elderly.

4.2 Response rate

14 participants were involved in the research with 9 elderly women and 5 elderly men. These had come to collect their medication at Shurugwi District Hospital. The researcher got 100% response rate having all participants actively responding to the questionnaire.

4.3 Demographic characteristics of respondents

Table 4.1

Key characteristics of the participants

Participant pseudonym	Age range	Sex	Relationship Status	Level of education	Occupation
1	50-54	F	Widow	Ordinary level	Nurse Aide
2	55-59	F	Widow	N/A	N/A
3	50-54	F	married	N/A	General hand
4	60-64	F	Widow	Diploma in Theology	Church Admin
5	50-54	F	Widow	N/A	Vendor
6	54-59	F	divorced	BED / History	Teacher
7	64-69	M	married	Diploma in Education	Farmer
8	50-54	F	divorced	N/A	Sex worker

9	55-59	F	Single	St 4	Self employed
10	55-59	M	married	Honors degree in Survey	Surveyor
11	50-54	M	divorced	N/A	Vendor
12	55-59	M	divorced	N/A	Gold digger
13	55-59	M	married	Diploma in Engineering	Boiler maker
14	55-59	F	Married	Grade 7	Vendor

Table 4.1

The research was carried out on a sample of 14 participants who attend for treatment at Shurugwi Hospital.

4.4 Disclosure among the elderly

Data presented in this section was categorized into themes and subthemes in relation to the research questions of the study. Below are the questions:

1. What are the factors influencing disclosure among the elderly?
2. What are the consequences of HIV disclosure among the elderly?
3. What are some of the strategies do the elderly use to conceal their HIV positive status?

4.5 Theme 1: Factors influencing disclosure among the elderly

Table 4.2: Factors influencing disclosure among the elderly

Theme 1	Subthemes
Factors influencing disclosure	Fear of ageism
	Gender-based beliefs
	Fear of partners reaction
	Loss of trust
	Religiousness
	Cultural norms

Table 4.2

Table 4.2 shows the theme and subthemes found under the research question: what are the factors influencing disclosure among the elderly? The aim of the research question was to bring out issues that affect disclosure among the elderly. Research findings show that factors like fear of ageism, gender-based beliefs, fear of partner's reaction, loss of trust, religiousness and cultural norms. These research findings indicate that such factors determine whether one should or should not disclose his/her HIV status.

4.5.1 Fear of Ageism

From the carried out research, the majority of the participants clearly agreed that age had an effect on HIV disclosure among the elderly. Due to the way HIV is transmitted, ageism became a point to note in the factors that influence disclosure among the elderly. The majority of the participants justified how much HIV disclosure could be affected by age. Some of the participants' comments were as follows:

“Yes age can affect disclosure very much. My wife is 26 years younger than me and I married her without the virus. If I tell her now that I am HIV positive she will leave me fearing that I will affect her health of which it's very shameful because she is negative and I had told her that I'm also negative but I really know my status. And I don't want people to say that this old man married this young woman just to destroy her future, I do not want that”.

(Participant 13)

“Yes age can affect disclosure of HIV. As old as I am, how will I tell people that I am HIV positive? Our age can not be associated with something like that (laughs). It's a shame for me to be known that I am positive. People expect the elderly to lead by example so it is a shame to be HIV positive.”

(Participant 1)

“Age greatly affects my ability to disclose my HIV status. People will start to think I am ill mannered and that I do not have boundaries in my social life or I did not have enough parental advice when I was a young adult in such a way that I behaved anyhow, its indeed a humiliating situation”

(Participant 2)

These findings indicate that age has got a close link with disclosure. From the given comments, it can be noted that there is a perception among the elderly that HIV is a disease that is associated with young adulthood. Therefore, this perception creates a barrier for disclosure amongst the elderly. More so, from the above comments, age difference among married couples becomes a point to note in hindering disclosure which can result in transmission of HIV from partner to another.

4.5.2 Gender-based beliefs

Findings from the research showed that gender result in stereotypes among men and women. Majority of the participants reported how much HIV was associated with risky behaviors. Because of this, they felt that it was impossible to share their HIV statuses with others as they also feared to be associated with these risky behaviors. Some of the comments from the respondents were as follows:

“If you ask anyone around here, they can tell you that HIV is high among men. Why men, because they are the ones who can have as many women as they want. To be honest, HIV is associated with every risky behavior you can think of e.g. excessive alcohol consumption which causes one to lose sense of reality and results in multiple sex partners. Everyone knows it’s for men, so even if they say now I am HIV positive we know where it came from. As for me, I am a widow, I do not know what led to the death of my husband and all of a sudden I come out and say I am positive (laughing), its impossible. People will also think I’m also associated with these behaviors.”

(Participant 2)

“I can not disclose mwanangu, if I die, people will simply say it is old age that killed me not HIV. The kinds of things that are associated with this disease are not right especially for us women... I have known one man, who happens to be the father of my children and a grandfather; He believes that he is very healthy, so he does not want us to be tested. I secretly got tested when I had continuous headaches for a very long, but I did not tell him. I know he has other women out there, and every man can do it.

(Participant 3)

The above findings clearly indicate that there are beliefs that risky behaviors only are familiar with men. Therefore, this hinders women to disclose about their statuses since they tend to believe that only men are the ones expected to have marital affair and women expected to be monogamous.

4.5.3 Fear of partner's reaction

The findings from the research show that awareness of partner's status has a positive impact on disclosure as it determined individual's ability to disclose. Participants reported how much being aware of partners' status helped them to personally decide their level of disclosure as they did not know what to expect after disclosure. Below are some of the comments given by the respondents:

“My husband tested negative long ago, and because we were staying apart, I also went for an HIV test and tested positive. So it's a challenge for me to tell him that I am positive. Obviously he needs an explanation concerning my results. It's difficult situation for me because I do not know what he will do next after I tell him, already he is a problem.”

(Participant 4)

“Yes, she is an HIV negative young woman who I married recently and I am positive. What if she leaves? She may think that I got HIV from my previous marriage and this may greatly affect my marriage with her. “

(Participant 13)

From the research it can be deduced that awareness of partner's status contributes to non-disclosure. Results indicate that if participants know that their partner is also positive, there is high probability of non disclosure.

4.5.4 Loss of trust

Due to the transmission of HIV through sexual intercourse, elderly participants reported how disclosure could affect the status of their relationships. Though infected with HIV and fearing disclosure, participants reported how the issue of condom use after staying in marriage for many

years could raise questions that could affect their marriages. Relationship status mostly affected disclosure on the part of married individuals. Some of the participants reported as follows:

“We have been married for more than 40 years and we have been enjoying our marriage very much. Recently I got tested because of constant headaches and I tested positive, but I did not tell my husband. I am afraid to tell him because I think he may start suspecting something serious and I can not suggest methods of having sex because I am a woman.”

(Participant 6)

“The situation is just unbearable. I used to own a shebeen and everyone knew me. So in these past years I moved from my area to Shurugwi to start a new life and I found a man who wanted a serious relationship with me and I agreed. But now I am afraid to tell him of my status and my history because he might still think that I am still that old person (laughs). I am planning to tell him, but not now, but very soon”

(Participant 2)

From the above findings, individuals fear HIV positive status disclosure because of the unexpected negative outcomes that may arise within the marriage. This also indicates that women are more likely than men to bring HIV into an intimate partnership.

4.5.5 Religiousness

Findings from the research indicate a role played by religion in affecting disclosure. Because of being expected to have a specific belief in order to be identified with a certain group (pastors and members of the same faith) participants reported how this impacted their decision to disclose or not to disclose. Some of the comments were:

“I am a Christian and I believe in healing through prayer and deliverance and personally I have gone to see a pastor for personal deliverance. Therefore, I cannot tell people that I am sick when I am healed; it simply shows your level of faith. I just take these ARVs as a method for all people living with HIV.”

(Participant 13)

“I am a Christian and it’s a shame that I can not tell my pastor that I am HIV positive because of the position I have in church, everyone will know it. Besides, if the pastor

shouts you are healed, you can not deny it even if you know that you still have your HIV (Laughs). You just know it in your heart. I just do not want anyone in church to know about my status.

(Participant 4)

Religion shapes individual's decision concerning disclosure. Research shows that the individuals fear to disclose because they want to go with the flow of their beliefs as Christians and others want to protect their positions in church.

4.5.6 Cultural norms

Findings from the research indicate that cultural norms also play a role in influencing disclosure among the elderly mostly on the part of women. Some societies consider promiscuity as acceptable in men as it is associated with risky sexual behaviors following too much alcohol consumption. Majority of the participants reported as follows:

“Being a woman tested positive to HIV is considered to be reckless living. Those are things to be associated with men and also common among men because they are the ones who can have as many women as they want.”

(Participant 6)

“I do not tell anyone about my status because I feel it to be inappropriate to the community. People highly praise us, so if such a circumstance befalls you every one is forced to say something bad about the thing they once praised you for”

(Participant 10)

Findings show that such a social construction designed for women affects their ability to disclose as they do not want to be associated with risky behaviors.

4.6 Theme 2: Consequences of HIV Status Disclosure among the elderly

Table 4.3: Consequences of disclosure among the elderly

Theme 2	Subthemes
Consequences of HIV status Disclosure	Enacted stigma
	Accusations of infidelity
	Gender stereotypes
	Violence
	Shrinking of social network

Table 4.3

Table 4.3 gives a summary of the subthemes. The research question seeks to bring out the negative outcomes of disclosure in the lives of the elderly living with HIV. Some of the participants reported to have disclosed while others had not yet disclosed fearing the negative outcomes of disclosure. All the reported experiences of aging with HIV revolved on fear and stigma.

4.6.1 Enacted stigma

The majority of the participants reported that their positive status was associated with a lot of stigma and discrimination. Stigma and discrimination has been reported to be very common among people living with HIV especially around people without adequate knowledge about the disease. The majority of the participants reported as follows:

“We were at a relative’s funeral at one time and my brother refused to make use of the cup I had used to drink water. When he saw that I had seen what he had done, he tried to cover up, but I saw it.”

(Participant 13)

“When I told my daughter that I was HIV positive, she exclaimed that I was very old to have HIV and there was no way it could be possible.”

(Participant 1)

From the above, stigma and discrimination remains a block to disclosure for many people. HIV positive patients fear negative outcomes of disclosure.

4.6.2 Accusations of Infidelity

Research findings indicate that accusations of extramarital affairs or being unfaithful to spouse were reported to have influenced individual's willingness to disclose. Blame was reported to hinder disclosure amongst married couples from both partner and members of the family as well as amongst widows. Some of the participants reported as follows:

“I have not yet told my wife because I fear to be blamed of promiscuity, if we were both HIV positive it would be better. We divorced twice and got back together because of the issue of extramarital affairs.....”

(Participant 10)

“My wife's relatives talk too much, especially her sister (laughing). I may be accused of having other women apart from her. HIV can be contracted any how (laughing). Who can understand that? I will be a bachelor by the end of the day”

(Participant 11)

Findings show that the participants who feared accusations of infidelity were men mostly who seemed to have married much younger women than them. Findings indicate that these men were not in their first marriages.

4.6.3 Gender stereotypes

Findings from the research show that there is existence of gender stereotypes which results in elderly women being blamed for infecting partner. Amongst the participants, widows reported the consequences of disclosure. Some of the reports were as follows:

“When my husband became very sick, we went for HIV testing and he tested positive. I explained the situation to his sister because during those days ARVs were bought. I told his sister but his sister denied it. They took my husband to witch doctors all over seeking for assistance. I remember they left me behind and they went as far as Gutu and they were told I had something to do with his sickness. After he died they accused me of contributing to his death because of the properties he had. After his death I got tested again and found out that I was positive. Honestly, I could not tell them and I will not even tell them of my status.”

(Participant 4)

“When my husband died his relatives called me a witch because of the condition he died in. He was HIV positive but they did not believe it. This has caused me to keep my status between me and my children only.

(Participant 1)

Findings show that it is lack of knowledge that results in gender stereotypes. Fear of being accused of bringing HIV to partner by family members hinders elderly women to disclose HIV positive status.

4.6.3 Violence

Abuse in all its forms affects individuals’ ability to disclose. Some participants have heard testimonies of others who experienced abuse and when they tested positive they felt they could not tell because of what they had seen and heard. Participants responded as follows:

“We met at Manokore where I cooked sadza for “makorokoza”. He is younger than me and very violent. He will kill me. One day when we were having a general conversation he said to me that if he tests positive both him and me will find ourselves lying in the graves because it is me who will have given me the virus because of my age”

(participant 8)

“I did not know my status until my husband got tested and was found positive. He came home that day and beat me saying that I gave him the disease and that I got the disease the days I worked in South Africa. He gathered the children and called his relatives and told them that I gave him HIV. After the incident he left home, but whenever he could think of his status he would come home and would start shouting saying I gave him a death sentence. He called me all sorts of names and the almost everyone knew about my status. However, he died. Haaa what I saw in those years is really a story to tell (laughs).”

(Participant 6)

From the given comments, participants live in fear of abuse and some have experienced abuse which can come in all forms. As a result of this they regret disclosure because of its negative

consequences. Physical assault is mostly on the part of HIV affected women than it is on the part of men.

4.6.4 Shrinking of social network

Participants reported how much they needed family for support in times of hardships and reported to have disclosed hoping for the better. However, it was not as much as they were expecting. Some of the comments were:

“My husband died and I do not know the exact cause of his death. When I told his brothers that I had tested positive, they said that I had to look after myself and my orphans. They told me never to expect anyone at my gate with a loaf of bread because each of them had their own families to take care of. Ever since that remark none of my husband’s relatives has ever knocked at my door. I have worked for my children and the other one is about to get married, not even one of her relatives seem to care.”

(Participant 1)

“When I told my step daughter that I was HIV positive she came and took her daughter I had stayed with for almost 4 years because of her job. I told her that she had taken her child away from me because of my status, but she denied it. I know that my status is the reason why she took her daughter from me.”

(Participant 3)

Findings show that people have got a perception that if an individual has tested positive, he or she will die any time soon and they view it as a burden to have an HIV positive family member and they do not want the responsibility of taking care of a sick person.

4.7 Theme 3: Coping strategies used by the elderly to conceal a positive HIV status

Table 4.4: Coping strategies

Theme 3	Subthemes
Strategies used to cope with disclosure	Privacy
	Spirituality

Table 4.4

Table 4.4 indicates the subthemes found in the study. The research indicates how coping strategies were used for aging with HIV among the elderly. Participants who had disclosed reported how they tried to cope with living with HIV in a stigmatized environment and some reported their various methods they used to conceal their HIV positive status from other people. From the research, some participants have not yet disclosed to any one and just a few participants have either disclosed to a sister, a relative, and spouse or to children. However, to remain anonymous, from the rest of the people, they used several strategies to cope up with living with HIV in their environment as highlighted below.

4.7.1 Privacy

Keeping positive HIV status from people has enabled individuals to cope with living in an environment with stigma and discrimination. To avoid further stigma discrimination, participants reported as follows:

“Paracetamoles of these days have a similar shape with ARVs. So I change the packaging and I throw away the ARV container so if anyone happens to catch me by surprise they just assume I’m taking paracetamoles.”

(Participant 4)

“I always change packaging of my pills from a plastic bottle in to a plastic sachet that if I’m to take them, people will not even suspect that they are ARVs”

(Participant 1)

Findings indicate that privacy is helping individuals to live with the virus among people unaware of their HIV status.

4.7.3 Spirituality

Research findings indicate how spiritual belief systems became a successful coping strategy for aging with HIV. For the participants who had disclosed their positive HIV status to others against all odds reported how they were able to live without taking into consideration the negative outcomes of disclosure. Majority of the participants reported how much having a personal relationship with God was of vital importance. Some of the comments were as follows:

“After the death of my husband to HIV and what I went through as a result of my status I realized that God only will always be by my side. My personal relationship with God has greatly helped me to cope with experiences that can cause me stress. I overlook them and move on with my life.”

(Participant 5)

“When I tested positive I had bitterness and anger and I accused my late husband for giving me the disease. After some prayers and counseling I realized that one day we shall all die, either with this or that, but all is death. I do not want what people think affect me anymore because I had a lot of accusations, abuse and discrimination after the death of my husband and this made me bitterer, I take my pills freely and I really adhere to my treatment, but when I come to think of all the harsh treatment, it steals my joy.”

(Participant 6)

From the findings, spirituality provides a sense of peace and hope through prayers and faith in God. People who believe that they are facing serious challenges use spirituality in order to process life experiences in a positive way thereby fostering psychological wellbeing.

4.7 Chapter Summary

This chapter gives interpretation and analysis of data given by participants at Shurugwi District Hospital. People living with HIV are living in pain and fear of stigmatization, blame, rejection, fear of losing their families and financial support. Their level of disclosure is determined by the things they have seen, heard and perceived concerning their condition. In this chapter various

themes were deduced in relation to the research questions of the study. The themes were justified by the given responses by the participants.

CHAPTER 5

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

Chapter 5 displays the final segment of this project. It discusses whether the data collected justify and answer the research questions in the study. This chapter also concludes the study and gives recommendations to be adopted. The research study looked at factors that influence disclosure among the elderly in Shurugwi District.

Research findings indicate that elderly people experience considerable amount of stigma (Emlet 2006b, 2007). It was notable that in this population of the elderly people living in Shurugwi, a significant number of respondents answered to have not disclosed their status. It is important that being recognized as different by others in the general public and additionally inside the family can be a source of stigma since one is named as being extraordinary (Goffman, 1963). As indicated by Goffman's portrayal of the social mark of contrast, stigmatized people are constrained to see themselves as different and additionally the general public also and this stresses the way that stigma emerging from this frame could entangle the take-up of HIV care and treatment even in circumstances where people are asymptomatic (Kuteesa et al, 2014).

5.2 Factors influencing HIV disclosure among the elderly.

The findings from the research indicated that fear of ageism, gender-based beliefs, fear of partner's reaction, loss of trust, religiousness and cultural norms are some of the factors that influence HIV disclosure among the elderly. These factors determine whether the elderly should or should not disclose their HIV status to intimate partners, friends or family.

Research findings indicated that age played a significant role in disclosure as it influenced individual's willingness to or not to disclose. Older women were less likely to disclose to their sexual partners than young adults. The findings from the research showed that fear of ageism influenced the individual's ability to disclose. These findings are similar to those of Brennan-Ing

(2017) who noted that HIV is perceived as a disease of the young adults. Because of the perception that HIV is a disease of the young adults, the elderly do not want to be associated with it. Gaskins (2006) noticed that younger individuals would probably reveal their HIV status dissimilarly to the elderly. All the more along these lines, past study proposed that older age was related with increased HIV stigma and less disclosure. (Emlet, 2006a). In particular, the existence of HIV research projects may have positive effects on disclosure and associated HIV stigma. Similar findings were reported by Maman et al. (2009) and Zou et al. both of which found older age to be a predictor of HIV serostatus disclosure. This study was carried in Tanzania (Kiula et al, 2006).

The study found out that gender based beliefs play a major role in influencing disclosure. These findings are similar to those of Mswela (2009) who carried out a research in South Africa and found out that multiple partnership is allowed and very much encouraged for men while for women it is not allowed. In his findings, Mswela (2006) noted that women are expected to be monogamous and are not allowed to question their partner's behavior. A similar study on sexual and reproductive health of South Africa showed that men tend to lack self control and feel indomitable which could therefore undermine their risk's perception Stern et al. 2014). Older women who were involved in this study felt relegated to accepting that men have the right to multiple partners. A study by Lofti et. al (2013) justified these findings where women faced difficulties in allowing men to have multiple partners. These findings clearly justified the close link between disclosure and beliefs based on gender.

Fear of partners' reaction was also found to be influencing disclosure of HIV status among the elderly. These findings were similar to those of Nyaribo (2015) who indicated that individuals attributed disclosure to time factor due to the fear of partner's reaction. The researcher found this quite interesting, given that some respondents had lived with their partner for over ten years and had not been able to disclose. It was also established from the study that most respondents from the undisclosed group expressed their desire to disclose to their friends and family, however they said they were helpless for they did not know how to go about it and how the partner would react after disclosure.

The findings in this study showed the impact of religiousness on disclosure. Research findings indicated that religiousness prevents the elderly to disclose their HIV status. However, these

findings differ from those of Zou et al (2008) who in their study indicated that disclosure was an aspect that could be addressed by religious leaders in reducing stigma associated with HIV and persuade the community to hold up individuals and the families affected and infected by HIV. They further highlighted that older Christians were willing to disclose their HIV positive serostatus. As highlighted in the research, religiousness is closely linked to disclosure due to fear of being stigmatized. Religious convictions influence HIV status disclosure as it might be related with the conviction held in a few religions that it is a discipline from God (Zou et al.2008). Religious pioneers have an extra supportive part, as one can ordinarily share secret data without dread of reproach. Nonetheless, in this investigation it created the impression that people favored not to talk about their HIV positive statuses with their religious leaders because they feared disgrace.

Findings from the research show that cultural norms also contribute to the individual's decision to disclose or not to disclose. Research findings indicated that the decision to disclose was enormously affected by socially decided, community level shame and standards. Similar to these findings was a study by Baloyi (2009) who stated that social construction of standards intended for African women indicate that sexual intercourse was not likely to be a long life practice for elderly women. In his findings he concluded that this greatly affected disclosure more on the part of women. According to Barret et al (2005) and Dako-Gyeke (2013), some of these socio-cultural factors that allowed male promiscuity resisted fidelity and put women on risk of infection. It is therefore, not startling that older men were reported to be more sexually active than older women (Nguyen & Holodniy, 2008). Most societies in Africa were found to be accepting extra marital affairs among men (Rankin et al. 2005). Their findings indicated that they supported male promiscuity and placed a high value on female fidelity (Haruna & Ago, 2014). According to (Scott, 2009), these cultural practices positioned elderly women on a particular difficulty concerning safer sex practices. These findings however, highlighted the impact of disclosing an HIV positive status among elderly women.

5.3 Consequences of HIV status disclosure

In regard to consequences of disclosure, Stigma and discrimination, negative responses, loss of family support, loss of financial support, and fear of abuse were found to be the key constraining factors to all respondents. However, on the part of those who disclosed there were negative

consequences which followed their willingness to disclose and these included stigma, violence, gender stereotypes as well as accusations of infidelity, violence and shrinking of social networks. Some of the respondents generated many comments about negative consequences that followed after disclosure.

Research findings indicate that stigma and discrimination are a consequence of disclosure and that stigma and discrimination, actually, cuts across all the interactions in the lives of the elderly living with HIV. According to testimonies of respondents, fear is a major problem. These findings were found to be similar to those of (Nyaribo, 2015) who noted that although disclosure has both negative and positive effects, it is more generally linked to better and more positive living. Stigma affects the psycho-social environment and the physical environment of an individual with HIV, as well as the partner, family and friends. This makes the process of disclosure extremely difficult because it makes one vulnerable to being devalued as a human in a particular social context (Norman et al., 2007). Therefore, stigmatization has a major negative influence on disclosing a socially devalued illness or condition, such as HIV (Greig et al., 2008).

Findings of this research indicated that shrinking of social networks was notable after one had disclosed his/her positive HIV status. This was clearly a result of stigma and discrimination in which a positive elderly was exposed to. Social isolation was caused by withdrawal of relatives and friends after disclosure. These findings, however, did not align to those of Nobre et al (2016) who conducted a study on the social network of the elderly. His findings indicated that participants' social network were large. He noted that acquaintances and relatives were the primary source of casual support. The majority of participants relied mostly on their acquaintances, some of whom were HIV-positive. However, Nobre et al (2016) concluded that in years to come, social networks of older adults living with HIV would shrink due to personal reasons other than HIV-disclosure. Nobre's conclusions were similar to the findings of Kuteesa et al (2014) who found out in their study that shrinking of social networks was a result of other reasons apart from HIV related stigma resulted by disclosure.

Violence physical abuse is another consequence of disclosure of HIV status. All female respondents who had not disclosed mentioned fear of violence. Respondents mentioned that violence manifested through assaults, and physical assault. In the context of gender equality male attitudes and behaviors appeared to be the centre of HIV/AIDS problems (Nyaribo, 2015).

Findings from the research indicate that gender stereotypes allow women to be blamed for spreading HIV infection (Rankin et al. 2005). These findings are similar to those of Peacock who noted that men are often reported to be infected by women, who may be castigated by men and women alike, while less blame tends to fall on men as opposed to women who have multiple partners (Peacock et al. 2008). If HIV infection is discovered in a wife first, she is readily blamed by her husband and, and in some instances, women may equally be blamed by other relatives, regardless of whose infection was discovered first (Peacock *et al.* 2008). As Mbonu, Van lair Borne and De Vries (2010) noted, men and women who are infected with HIV experienced a similar sickness, yet society's tendency to the accepted meek position of women presented them to a great degree of negative reactions (Higgins, Hoffman, Shari and Dworkin, 2010). The dread of being reprimanded for tainting a partner was to a degree in charge of absence of disclosure of HIV status among partners (Peacock et al. 2008). Tagwirei (2014) states that accusing both of the sex serves to strengthen shame against the community which is already suffering the scourge of the plague, hence gender stereotypes generalizations influence disclosure among the elderly.

The research findings of the study indicated that loss of trust was a notable consequence of HIV disclosure among the elderly determined whether an individual should or should not disclose. From a study that was carried out in Botswana by Keetile (2010), his findings justify the findings of this research on trust and disclosure. In his study he indicated that elderly men were likely to have sexual partners who were 10 times younger than them and were at much higher risk of getting infected by HIV. The elderly men's involvement in extramarital affairs with these young females likely put these elderly men on risks of HIV who, because of trust issues would not suggest the use of condoms for safer sex with their elderly women. He noted that the same men would infect their elderly female sexual partners after having unprotected sex with young females (Smith, 2007). Nguyen and Holodniy (2008) agree with the findings of Keetile (2010), by noting that older women were at much higher risk of getting infected by HIV because of menopausal changes in the mucosa of the vagina thereby increasing the likelihood of sexually transmitted disease and HIV (Ramjee & Daniels, 2013).

5.4 Strategies used to conceal a positive HIV status

The research findings indicate that HIV positive elderly men and women use coping strategies either to conceal a positive HIV status or to cope with the consequences of disclosure. The research findings highlighted that the individual's own acceptance of his or her positive HIV status helped in confronting stigma related to HIV among the elderly. Similar to previous studies, there was evidence that older HIV positive adults have developed ways of managing life with HIV (Emlet et al. 2010). Nevertheless, many claimed to have largely overcome stigma, there were times and situations where they felt stigmatized because of their HIV status. The state of 'being or feeling stigmatized' was not constant. Similarly, perceptions about stigma do not necessarily disappear with time (Dowshen, Binns & Garofalo, 2009). Kuteesa et al (2014) explained that changes in behaviour and opinions about stigma could be a result in punctuations in health and support from others, feelings of isolation, the respondents' changing attitudes towards HIV/AIDS as well as a sense of empowerment through intolerance of stigma.

Findings indicate that coping strategies were essential in mediating the association of HIV stigma and psychological well-being. Spirituality and privacy were found to be coping strategies among the elderly living with HIV. Similar to these findings was a study by Vance (2011) who supported this by demonstrating a partial mediation of HIV stigma from spirituality on psychological well-being. Thus, spirituality is affirmed as an element of positive aging with HIV (Vance et al., 2011).

Generally most respondents who had disclosed agreed that after disclosure, there was availability of social support, which was critical due to the difficulties they had gone through. This stemmed from the fact that with no disclosure it was difficult to use prescribed medication in the company of other people and this was found to be affecting adherence. It was difficult to have the privacy that would keep people from noticing regular medication use. Counselling was experienced as enhancing individual's well-being. Individuals mentioned that counselling addressed fears and was a tool for accepting and coping with HIV status.

5.5 Conclusion

Stigma and discrimination associated with HIV are recognized as barriers to effective HIV disclosure and prevention, diagnosis, treatment care and support. They are associated with poor health and psychosocial outcomes and may lead to greater challenges among the elderly living with HIV.

Findings from the research highlighted that demographic characteristics have got an influence on HIV positive status disclosure. Findings highlighted that age, culture, religion, marital status play a significant role on impacting disclosure among the elderly. Findings also show that elderly women are at possible risks of facing the consequences of disclosure both from partners and family members. This process might be facilitated by gender. Elderly women are more affected by HIV-related stigma. Though most research on stigma among people living with HIV examines its determinants on individual level, stigma does not begin within the individual. Prejudiced norms and beliefs are built and perpetuated within the communities, institutions and societies at large. Stigmatising beliefs are consequently apparent and internalized by individuals.

Findings indicated that disclosure of HIV positive status greatly affects elderly women than it does on men. Stigma perceived at community level, with other various factors such as predictable stigma, depressive symptoms and older age predict non-disclosure of HIV status. Conclusions from the research indicated that stigma encompasses every aspect at social levels. However, the HIV positive status disclosure is vital for both men and women as it promotes health, gives room for social support, preventative measures against the spread of HIV and promotes the wellbeing of both the affected and the infected. Findings also show that there is a tension between a call for disclosure as a prevention measure and there is need to understand women as possibly affected by HIV status disclosure both physically and socially.

In view of the consequences of HIV disclosure among the elderly, it can be summed up that lack of adequate knowledge about the disease plays a role in disclosure. There is a slight relationship between the negative consequences of disclosure and level of education. Individuals with no proper education have the highest prevalence of imposing negative treatment on the elderly who disclose willingly as compared to those with better education.

Studies have indicated that the issue of disclosure among the elderly living with HIV results in them to acquire strategies of coping with a stigmatized environment and/or prevent others from knowing their HIV statuses. The strategies they implement are useful for emotional support as they aim at reducing and eradicating the consequences of disclosure. Secrecy, social isolation and mastery were some of the strategies that the elderly use to conceal their HIV positive status. Research findings highlight the impact of HIV stigma on the elderly and more studies are being carried out to identify characteristics that may serve as protective measures against HIV stigma on individuals (Brennan, 2004).

5.6 Recommendations

- There is a need for Community- based programs to inform people on the need to lessen stigma linked with HIV.
- More social support groups are needed to support HIV infected individuals especially in remote areas.
- There is need for promoting couple counselling in order to facilitate positive outcomes and minimize negative outcomes of disclosure.
- Elderly women should be mentally equipped with enough knowledge as to enable them to cope with a stigmatized situation and overcome the consequences of disclosure.
- The general population should be well-informed about the magnitude of disclosure so that perceived consequences of disclosure like stigma can be addressed and prevented.
- There is need to construct culturally relevant behavioral intervention programmes for important behavior change for the elderly.
- There is undoubtedly a need for more investment in health sector initiatives to promote voluntary testing and disclosure of HIV status.
- Preventative measures based on social and cultural reality need to be hunted to empower elderly women.
- Similarly, there is need to create platforms for the elderly men so that they reconsider their cultural practices that look down upon women and promote male dominance also consider their implications on elderly women.
- There is need for constructing a support network to safe guard against the potential risks of disclosure against the elderly.

- There is need to educate the elderly on condom use and prevention.
- There is need for in depth and wide research in this area of study.

5.7 Study Limitation

The study looked at factors influencing disclosure among the elderly in Shurugwi. However, the findings of the research that affect the elderly in Shurugwi may not affect the elderly in another area due to variability of culture. The study implemented qualitative approach with a phenomenological design which is also limited methodology because of its small sample size hence cannot be quantified as it is subjective to the researcher. More, so the study consisted of more elderly women than elderly men thereby affecting generalization of data.

5.8 Chapter Summary

Chapter 5 is the summation of the whole research. The researcher focused on discussing the findings of the research. Conclusions were done for each research question as well as the recommendations for the problems faced by the elderly living with HIV were also highlighted in this chapter.

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8. How does your gender influence disclosure?
9. Are you aware of your partners' status? Can you please explain how this influences disclosure on your part.
10. How does your relationship status influence your ability to disclose your status?
11. Please identify your religion and explain how it influences disclosure.
12. What is the impact of your culture on disclosure?

SECTION C: CONSEQUENCES OF HIV DISCLOSURE AMONG THE ELDERLY

13. When did you learn about your HIV status?
14. Did you disclose to anyone?
15. If yes, to whom did you disclose to about your HIV status?
16. How did the person you disclosed to react?
17. What did the reaction made you feel?
18. What are some of the possible reasons that made you to disclose your HIV status?
19. How did you feel after you disclosed your status?
20. Below are some of the possible reasons that can hinder your ability to disclose your HIV status? Can you please relate to the following consequences of disclosure:
 - i) Stigma and discrimination
 - ii) Shame
 - iii) Fear of blame and rejection
 - iv) Fear of losing family support
 - v) Abuse
 - vi) Fear of losing financial support

SECTION D: COPING STRATEGIES

21. How do you cope with HIV and aging?

This marks the end of the interview. Thank you for your participation.

APPENDIX B: LETTER FROM ORGANISATION

**Midlands State
University**



Established 2000

P BAG 9055
GWERU

Telephone: (263) 54 260404 ext 2156
Fax: (263) 54 260233/260311

**FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY**

Date: 18.10.17.....

To whom it may concern

Dear Sir/Madam

RE: REQUEST FOR ASSISTANCE WITH DISSERTATION INFORMATION

FOR VANDIRAJI SHEETER.....

BACHELOR OF PSYCHOLOGY HONOURS DEGREE

This letter serves to introduce to you the above-named student, who is studying for a Psychology Honours Degree and is in his/her 4th year. All Midlands State University students are required to do research in their 4th year of study. We therefore, kindly request your organisation to assist him/her with any information that she/he requires.

Topic: Factors affecting HIV status disclosure among the elderly in Shurugwi District

For more information regarding the above, feel free to contact the undersigned.

Yours faithfully

N. Ncube
A/Chairperson



APPENDIX C: AUDIT SHEET

Research Project

Supervisor-student audit sheet

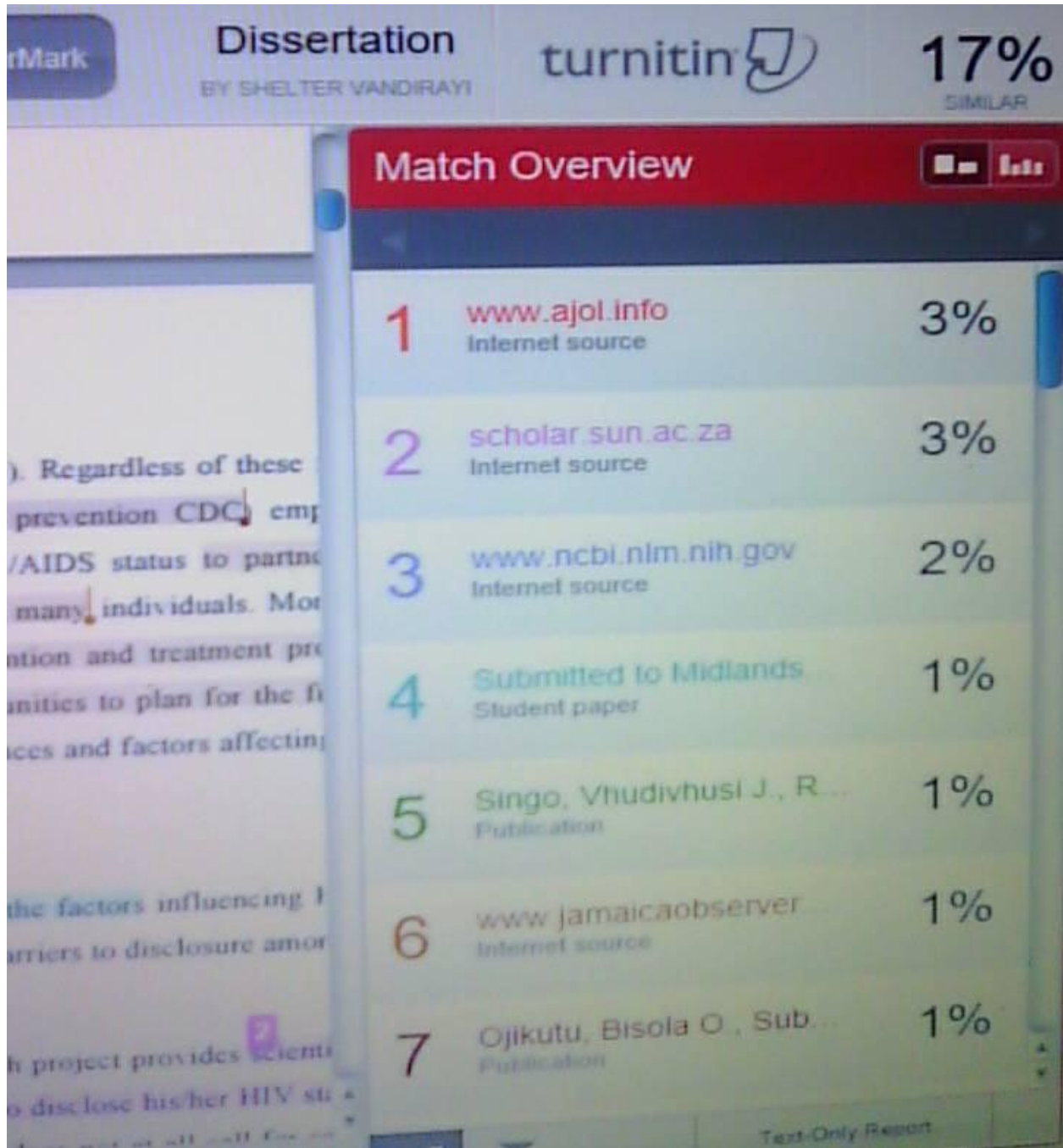
SHELTER VANDIRAYI- R144306P

DATE	ACTIVITY	COMMENT	SUPERVISOR'S SIGNATURE	STUDENT'S SIGNATURE
21/08/17	Topic discussion	Proceed		
06/09/17	Proposal submission	-		
12/09/17	Proposal discussion	Proceed		
05/10/17	Chapter 1-3 submission	-		
18/10/17	Chapter 1-3 discussion	Corrections and proceed		
22/10/17	Research instrument submission	-		
06/11/17	Research instrument discussion	Proceed		
12/03/18	Chapter 1-4 submission	-		
22/03/18	Chapter 1-4 discussion	Corrections		
30/03/18	Chapter 1-4	Proceed		
03/04/18	Chapter 1-5 submission	-		
09/04/18	Chapter 1-5 discussion	Corrections and proceed		
16/04/18	First draft submission	-		

Supervisor's signature.....

Date

APPENDIX D: TURNITIN REPORT



SUPERVISOR'S SIGNATURE.....

APPENDIX E: MARKING GUIDE Shelter Vandirayi R144306p

	ITEM	Possible Score	Actual	Comment
A	RESEARCH TOPIC AND ABSTRACT clear and concise	5		
B	PRELIMINARY PAGES: Title page, approval form, release form, dedication, acknowledgements, appendices, table of contents.	5		
C	AUDIT SHEET PROGRESSION	5		
D	CHAPTER 1 Background, statement of problem, significance of the study, research questions, objectives, hypothesis, assumptions, purpose of the study, delimitations, limitations, definition of terms	10		
E	CHAPTER 2 Addresses major issues and concepts of the study. Findings from previous work, relevancy of the literature to the study, identifies knowledge gap, subtopics	15		
F	CHAPTER 3 Appropriateness of design, target population, population sample, research tools, data collection, procedure, presentation and analysis	15		
G	CHAPTER 4 Findings presented in a logical manner, tabular data properly summarized and not repeated in the text	15		
H	CHAPTER 5 Discussion (10) Must be a presentation of generalizations shown by results: how results and interpretations agree with existing and published literature, relates theory to practical, implications, conclusions (5) Ability to use findings to draw conclusions Recommendations (5)	20		
I	Overall presentation of dissertation	5		
J	References	5		
K	TOTAL	100		

Marker.....Signature Date.....

Moderator.....Signature..... Date.....